

Non-Submission of OASIS Data

Medicare certified agencies must transmit OASIS data to the state server at least monthly. Agencies not submitting monthly are subject to an automatic deficiency at 484.20(c)-G tag 323.

This completed form must be faxed to the State Information/Data Services when your agency has not served clients requiring OASIS data collection and transmission during the reporting month. Our fax number is: 573/751-6315.

Date: _____

Provider Number: _____

Agency Name: _____

Reason for non-submission for previous month's OASIS data:

This information will be cross-referenced with the state's submission data reports.

If further information is needed, please contact Debi Siebert, OASIS Technical Coordinator at 573/751-6332.

* Home Health Compare Quality Measures 2005

All measures are part of the larger set of data, Outcome Assessment Information Set (OASIS), collected by Medicare-certified home health agencies.

- Improvement in Ambulation/Locomotion
- Improvement in Bathing
- Improvement in Transferring
- Improvement in Management of Oral Medication
- Improvement in Pain Interfering with Activity
- Acute Care Hospitalization
- Emergent Care
- Discharge to Community
- Improvement in Dyspnea
- Improvement in Urinary incontinence

* Effective 12/07 the following measures will be published. The updated quality measures in consumer language include:

- Percentage of patients whose wounds improved or healed after an operation (**New Measure**)
- Percentage of patients who need unplanned medical care related to a wound that is new, is worse, or has become infected. (**New Measure**)

As part of home care, the nurse must assess and instruct the patient or caregiver on the signs of normal wound healing, signs and symptoms of wound infection, wounds that are getting worse, or new wounds, and the importance of calling the home health agency first with concerns about the wound. The home health agency also has a responsibility to visit the patient frequently enough to assess the wound, assist in care for the wound according to the doctor's orders, and look for any preventable problems such as pressure relief and proper nutrition.

Downloads

NQF Endorsement [PDF 20 KB]

Related Links Inside CMS

FAQs

Medicare.gov

Home Health Compare

Related Links Outside CMS

Medicare Quality Improvement Community

Agency for Healthcare Research & Quality

American Association of Home Care

National Association for Home Care and Hospice

National Association State Units on Aging

National Quality Forum

National Quality Guidelines

National Pressure Ulcer Advisory Panel

Visiting Nurse Association of America

Wound Ostomy Continence Nurses Society

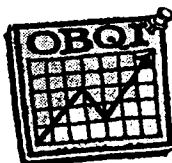
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2.

PPS

M0 Items Used in the PPS 2008 Case-Mix and NRS Models

OASIS Item	Description	Clinical Dimension (Table 2A)	Functional Dimension (Table 2A)	Service Utilization Dimension (Table 3)	Non-Routine Medical Supplies (NRS) Severity Level (Table 10A)
M0110	Episode Timing	X Determines Equation for point assignment	X Determines Equation for point assignment	X Determines Grouping Step for HHRG assignment	
M0230/ M0240/ M0246	Primary, Other, and Payment Diagnoses	X			X
M0250	IV/Infusion/ Parenteral/ Enteral Therapies	X			X
M0390	Vision	X			
M0420	Pain	X			
M0450	Multiple Pressure Ulcers	X			X
M0460	Most Problematic Pressure Ulcer ✓	X			
M0470	Number Observable Stasis Ulcers				X
M0474	Nonobservable Stasis Ulcer				X
M0476	Stasis Ulcer Status	X			X
M0488	Surgical Wound Status	X			X
M0490	Dyspnea	X			
M0520	Urinary Incontinence				X
M0540	Bowel Incontinence	X			X
M0550	Bowel Ostomy	X			X
M0650	Dressing Upper Body	X	X		
M0660	Dressing Lower Body	X	X		
M0670	Bathing	X	X		
M0680	Toileting	X	X		
M0690	Transferring	X	X		
M0700	Ambulation/ Locomotion	X	X		
M0800	Injectable Medications	X			
M0826	Therapy Need	X Determines Equation for point assignment	X Determines Equation for point assignment	X Determines Grouping Step for HHRG assignment	



OBQI OASIS Items Used in the Calculation of the Outcome Measures

Outcome Measure	OASIS Items Used	Time Points
All Outcome Measures	M0066 Birth Date M0090 Date Assessment Completed M0100 Reason for Assessment M0570 When Confused M0580 When Anxious	At SOC/ROC At SOC/ROC, used to calculate age; patient must be at least 18 and no more than 120 years) Episode must begin with RFA = 01, 02 or 03, and end with RFA = 06, 07, or 08 At SOC/ROC, must not = NA Patient nonresponsive At SOC/ROC, must not = NA Patient nonresponsive
All End-Result Outcome Measures	M0100 Reason for Assessment	Episode must end with RFA = 09
Improvement in Grooming	M0640 Grooming	At SOC/ROC and at D/C
Stabilization in Grooming	M0640 Grooming	At SOC/ROC and at D/C
Improvement in Upper Body Dressing	M0650 Ability to Dress Upper Body	At SOC/ROC and at D/C
Improvement in Lower Body Dressing	M0660 Ability to Dress Lower Body	At SOC/ROC and at D/C
Improvement in Bathing	M0670 Bathing	At SOC/ROC and at D/C
Stabilization in Bathing	M0670 Bathing	At SOC/ROC and at D/C
Improvement in Toileting	M0680 Toileting	At SOC/ROC and at D/C
Improvement in Transferring	M0690 Transferring	At SOC/ROC and at D/C
Stabilization in Transferring	M0690 Transferring	At SOC/ROC and at D/C
Improvement in Ambulation/Locomotion	M0700 Ambulation/Locomotion	At SOC/ROC and at D/C
Improvement in Eating	M0710 Feeding or Eating	At SOC/ROC and at D/C
Improvement in Light Meal Preparation	M0720 Planning and Preparing Light Meals	At SOC/ROC and at D/C
Stabilization in Light Meal Preparation	M0720 Planning and Preparing Light Meals	At SOC/ROC and at D/C
Improvement in Laundry	M0740 Laundry	At SOC/ROC and at D/C
Stabilization in Laundry	M0740 Laundry	At SOC/ROC and at D/C
Improvement in Housekeeping	M0750 Housekeeping	At SOC/ROC and at D/C
Stabilization in Housekeeping	M0750 Housekeeping	At SOC/ROC and at D/C
Improvement in Shopping	M0760 Shopping	At SOC/ROC and at D/C
Stabilization in Shopping	M0760 Shopping	At SOC/ROC and at D/C
Improvement in Phone Use	M0770 Ability to Use Phone	At SOC/ROC and at D/C

Instant OASIS Answers 2008

Outcome Measure	OASIS Items Used	Time Points
Stabilization in Phone Use	M0770 Ability to Use Telephone	At SOC/ROC and at D/C
Improvement in Management of Oral Medications	M0780 Management of Oral Medications	At SOC/ROC and at D/C
Stabilization in Management of Oral Medications	M0780 Management of Oral Medications	At SOC/ROC and at D/C
Improvement in Dyspnea	M0490 Short of Breath	At SOC/ROC and at D/C
Improvement in Urinary Tract Infection	M0510 Urinary Tract Infection	At SOC/ROC and at D/C
Improvement in Urinary Incontinence	M0520 Urinary Incontinence or Urinary Catheter Presence M0530 Urinary Incontinence	At SOC/ROC and at D/C
Improvement in Bowel Incontinence	M0540 Bowel Incontinence Frequency	At SOC/ROC and at D/C
Improvement in Speech and Language	M0410 Speech and Oral (Verbal) Expression of Language	At SOC/ROC and at D/C
Stabilization in Speech and Language	M0410 Speech and Oral (Verbal) Expression of Language	At SOC/ROC and at D/C
Improvement in Pain Interfering with Activity	M0420 Frequency of Pain	At SOC/ROC and at D/C
Improvement in Number of Surgical Wounds	M0440 Skin Lesion/Open Wound M0482 Surgical Wound M0484 Current Number of (Observable) Surgical Wounds	At SOC/ROC and at D/C
Improvement in Status of Surgical Wounds	M0440 Skin Lesion/Open Wound M0482 Surgical Wound M0488 Status of Most Problematic (Observable) Surgical Wound	At SOC/ROC and at D/C
Improvement in Cognitive Functioning	M0560 Cognitive Functioning	At SOC/ROC and at D/C
Stabilization in Cognitive Functioning	M0560 Cognitive Functioning	At SOC/ROC and at D/C
Improvement in Anxiety Level	M0580 When Anxious	At SOC/ROC and at D/C
Stabilization in Anxiety Level	M0580 When Anxious	At SOC/ROC and at D/C
Improvement in Behavior Problem Frequency	M0620 Frequency of Behavior Problems	At SOC/ROC and at D/C
Improvement in Confusion Frequency	M0570 When Confused	At SOC/ROC and at D/C
Utilization Outcome Measures		
Discharged to Community	M0100 Reason for Assessment M0870 Discharge Disposition	At Discharge or Transfer At Discharge
Acute Care Hospitalization	M0100 Reason for Assessment M0855 Inpatient Facility	At Discharge or Transfer At Transfer
Any Emergent Care Provided	M0830 Emergent Care	At Discharge or Transfer



OBQM
OASIS Items Utilized in the Adverse Event Outcome Measures

Adverse Event Outcome Measure	OASIS Items	Time Points
Emergent Care for Injury Caused by Fall or Accident at Home	M0830 Emergent Care M0840 Emergent Care Reason	At Transfer/DC
Emergent Care for Wound Infections, Deteriorating Wound Status	M0830 Emergent Care M0840 Emergent Care Reason	At Transfer/DC
Emergent Care for Improper Medication Administration, Medication Side Effects	M0830 Emergent Care M0840 Emergent Care Reason	At Transfer/DC
Emergent Care for Hypo/Hyperglycemia	M0830 Emergent Care M0840 Emergent Care Reason	At Transfer/DC
Development of Urinary Tract Infection	M0510 Urinary Tract Infection	At SOC/ROC and at DC
Increase in Number of Pressure Ulcers	M0450 Current Number of Pressure Ulcers at Each Stage	At SOC/ROC and at DC
Substantial Decline in Three or More Activities in Daily Living	M0280 Life Expectancy M0640 Grooming M0670 Bathing M0680 Toileting M0690 Transferring M0700 Ambulation/Locomotion	At SOC/ROC At SOC/ROC & DC At SOC/ROC & DC At SOC/ROC & DC At SOC/ROC & DC At SOC/ROC & DC
Substantial Decline in Management of Oral Medications	M0780 Management of Oral Medications	At SOC/ROC and at DC
Unexpected Nursing Home Admission	M0270 Rehabilitative Prognosis M0900 Reason(s) Admitted to Nursing Home	At SOC/ROC At Transfer/DC
Unexpected Death	M0280 Life Expectancy M0100 Reason for Assessment	At SOC/ROC At Discharge/ Transfer/Death

Instant OASIS Answers 2008

Adverse Event Outcome Measure	OASIS Items	Time Points
Discharged to Community Needing Wound Care or Medication Assistance	M0300 Current Residence M0350 Assisting Person(s) Other Than Home Care Agency Staff M0460 Stage of Most Problematic (Observable) Pressure Ulcer M0488 Status of Most Problematic (Observable) Surgical Wound M0570 When Confused M0780 Management of Oral Medications M0870 Discharge Disposition	At Discharge At Discharge At Discharge At Discharge At Discharge At Discharge At Discharge
Discharged to Community Needing Toileting Assistance	M0350 Assisting Person(s) Other Than Home Care Agency Staff M0680 Toileting M0700 Ambulation/Locomotion M0870 Discharge Disposition	At Discharge At Discharge At Discharge At Discharge
Discharged to Community with Behavioral Problems	M0350 Assisting Person(s) Other Than Home Care Agency Staff M0610 Behaviors Demonstrated at Least Once a Week M0870 Discharge Disposition	At Discharge At Discharge At Discharge

Source: Quality Monitoring Using Case Mix and Adverse Event Outcome Reports 01/2001,
 Section 3, accessed at
www.cms.hhs.gov/HomeHealthQualityInitis/18_HHQIOASISOBQM.asp#TopofPage

TABLE 8.1: Mapping of OASIS Items into Major Components of An Illustrative Patient Assessment at Start of Care.

Assessment Component and Elements Within Each Component	Related Patient Tracking Sheet/OASIS Item(s)
PREVISIT Telephone call prior to visit <ul style="list-style-type: none">• Telephone availability• Setting appointment time	M0770 M0770, M0400, M0410, M0560
VISIT Basic demographic information <ul style="list-style-type: none">• Name, address, age, gender, pay source, etc.	M0010-M0150
Entrance to home <ul style="list-style-type: none">• Patient's ambulatory status• Patient remembered telephone call & appointment	M0700 M0560, M0570
Interior of home (as move from one room to another) <ul style="list-style-type: none">• Odors (urine, feces)• Kitchen (where you might wash your hands)<ul style="list-style-type: none">- medications present in bottles or scattered• Bathroom (where you might wash your hands or what you ask to see to set up aide care plan)<ul style="list-style-type: none">- bathtub or shower- assistive equipment (grab bars, shower chair)- toilet- soiled clothes with urine or fecal odor- medications present in bottles or scattered	M0750 also M0520-M0540 also M0780-M0800 M0670, M0680 also M0520-M0540 also M0780-M0800
History of present condition and symptoms <ul style="list-style-type: none">• Hospitalization and reasons• Onset of current illness• Other comorbidities (severity and management)• Presence of high risk factors• Life expectancy	M0175-M0190 M0200-M0220 M0250, M0500, M0510 M0290 M0280
Family/caregiver assistance <ul style="list-style-type: none">• Living situation• Availability of family/caregiver assistance• Other assistance needed and received	M0300, M0340 M0350, M0360 M0360-M0380, M0820
Medication inventory <ul style="list-style-type: none">• Walk to where meds are kept• Assess knowledge of medication schedule, dosage, etc.• Assess ability to administer prescribed medications	M0690-M0700 M0410, M0560 M0780-M0800

Chapter 8: OASIS in Detail**Table 8.1: Mapping of OASIS items into Major Components of An Illustrative Patient (cont'd) Assessment at Start of Care.**

Assessment Component and Elements Within Each Component	Related Patient Tracking Sheet/OASIS Item(s)
VISIT (continued)	
Physical assessment	
<ul style="list-style-type: none"> • Vital signs <ul style="list-style-type: none"> - orthostatic BP - comprehension of instructions • Weight <ul style="list-style-type: none"> - comprehension of instructions - ability to stand, step on scale • Head <ul style="list-style-type: none"> - vision - hearing - speech • Skin condition • Musculoskeletal and neurological <ul style="list-style-type: none"> - joint function, grasp, pain, etc. - neurologic • Cardiorespiratory <ul style="list-style-type: none"> - dyspnea - lung sounds; check ability to dress upper body - circulation in lower extremities; check ability to dress lower body • GI/GU <ul style="list-style-type: none"> - urinary status - bowel status • Nutritional status 	M0690 M0400, M0560-M0570 M0400, M0560-M0570 M0690-M0700 M0390 M0400 M0410 M0440-M0488 M0640-M0660, M0780-M0820 also M0410-M0430, M0560 M0490 M0650 M0660 M0510-M0530 M0540-M0550 M0710-M0720, M0760 M0560-M0590, M0610, M0620
Emotional/behavioral status assessment	
ADLs/IADLs	
<ul style="list-style-type: none"> • Review any information not gathered already in sufficient detail 	M0670-0680, M0730-M0760
POST VISIT	
Data review (in preparation for care planning)	
<ul style="list-style-type: none"> • Primary diagnosis and comorbidities • Severity index • Prognosis and rehab prognosis • Need for psychiatric nursing services • Need for physical, occupational, or speech therapy 	M0230, M0240, M0245 (deleted 01/08) M0240 M0260, M0270 M0630 M0825 (deleted 01/08) M0826 (added 01/08)



OASIS ASSESSMENT REFERENCE SHEET

RFA * Type	RFA Description	Assessment Completed	Locked Date	Submission Timing
01	SOC - further visits planned	Within 5 calendar days after the SOC Date (SOC = Day 0)	Effective 6/21/2006 No required lock date	Effective 6/21/2006 Transmission required within 30 calendar days of completing the assessment (M0090)
03	ROC - after inpatient stay	Within 2 calendar days of the facility discharge date or knowledge of pt's return home		
04	Recertification - F/U	The last 5 days of every 60 days, i.e., days 56-60 of the current 60-day period.		
05	Other F/U	Complete assessment within 2 calendar days of identification of significant change of patient's condition		
06	Transferred to Inpatient Facility - not discharged from agency	Within 2 calendar days of the disch/trans/death date or knowledge of a qualifying transfer to inpatient facility		
07	Transferred to Inpatient Facility - discharged from agency	Within 2 calendar days of the disch/trans/death date or knowledge of a qualifying transfer to inpatient facility		
08	Died at home	Within 2 calendar days of the disch/trans/death date		
09	Discharged from agency: Not to Inpatient Facility	Within 2 calendar days of the disch/trans/death date		

* RFA= Reason for Assessment

RFA 02 and RFA 10 are no longer required records and are rejected by the state system

(Source: www.cms.hhs.gov/apps/hha/hharefch.asp Modified 7/19/06 to reflect change posted in Federal Register/Vol. 70, #246/Friday, December 23, 2005/Rules and Regulations, pg. 76199)

Revisions for RFA 3, 6, & 7 based on CMS 6/05Q&As Cat 2, Questions 2& 8 and 8/06 OCCB Q&As.
Revisions to RFA 1 based on OASIS-B1 Data Specification Notes July 24, 2003 pg. 6

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
Type of Episode or Adjustment	OASIS Assessment: M0100 & M0826 Response Selection & Comments
1. Initiation of home care for new Medicare PPS patient.	<p>Start of Care: (M0100) RFA 1 and (M0826) enter number of therapy visits indicated for the upcoming 60-day episode, or enter 000 if no therapy visits indicated.</p> <ul style="list-style-type: none"> o OASIS data elements are not required for Private Pay individuals effective December 2003. o Requirements for non-Medicare patients are found at: http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp Select fiscal year 2004 memorandum 04-26.
2. a) New 60-day episode resulting from discharge with <u>all goals met</u> and return to same HHA during the 60-day episode. (PEP Adjustment applies)	<p>Start of Care: (M0100) RFA 1 and (M0826) enter number of therapy visits indicated for the upcoming 60-day episode, or enter 000 if no therapy visits indicated.</p>
b) New 60-day episode resulting from transfer during the 60-day episode to HHA with no common ownership. (PEP Adjustment applies to original HHA)	<p>For the remainder of the current episode:</p> <ul style="list-style-type: none"> o Receiving HHA completes any required OASIS collection on behalf of the Transferring HHA. o PEP Adjustment does not apply if patient transfers to HHA with common ownership during a 60-day episode. o The Transferring HHA will serve as the billing agent through the end of the episode in which the transfer occurred.
3. New 60-day episode resulting from transfer during the 60-day episode to HHA with common ownership.	<p>At the end of the episode:</p> <p>OPTION 1: NEW PAYMENT EPISODE (Recommended) Receiving HHA completes a Discharge assessment (M0100) RFA 9 on behalf of the Transferring HHA Then Receiving HHA conducts a Start of Care assessment (M0100) RFA 1, establishing a new episode and certification, and completing all required admission paperwork.</p> <p>OPTION 2: CONTINUATION OF CURRENT PAYMENT EPISODE Receiving HHA continues to complete OASIS assessments at required Timepoints on behalf of the Transferring HHA. Transferring HHA remains the billing agent.</p>

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
Type of Episode or Adjustment	OASIS Assessment: M0100 & M0826 Response Selection & Comments
4. Qualifying Inpatient Stay with return to agency during (but not in last 5 days of) the current episode.	<p>OPTION 1: CONTINUATION OF CURRENT PAYMENT EPISODE (RECOMMENDED) at admission to hospital: Transfer without HHA discharge (M0100) RFA 6 at return to home care: Resumption of Care (M0100) RFA 3 and (M0826) enter number of therapy visits indicated for current episode, or enter 000 if no therapy visits indicated.</p> <p>OPTION 2: NEW PAYMENT EPISODE UPON RESUMPTION OF CARE at admission to hospital: Transfer with HHA discharge (M0100) RFA 7 at return to home care Start of Care (M0100) RFA 1 and (M0826) enter number of therapy visits indicated for upcoming 60-day episode, or enter 000 if no therapy visits indicated. <ul style="list-style-type: none"> ○ PEP adjustment applies to original payment episode </p>
5. Qualifying Inpatient Stay with return to agency during the last 5 days of an episode (days 56-60).	<p>OPTION 1: CONTINUATION OF CURRENT PAYMENT EPISODE (RECOMMENDED) at admission to hospital: Transfer without HHA discharge (M0100) RFA 6 at return to home care: Resumption of Care: (M0100) RFA 3 and (M0826) enter number of therapy visits indicated, or enter 000 if no therapy visits indicated. <ul style="list-style-type: none"> ○ When the requirement to complete a Resumption of Care assessment overlaps with the time period requiring completion of a Recertification assessment, only the Resumption of Care assessment is necessary. ○ Patient was transferred to an inpatient facility and returns home during the last 5 days of the current episode (days 56-60). HHA completes the Resumption of Care assessment (RFA 3) within 48 hours of the patient's return, as required. ○ For payment purposes, this assessment serves to determine the case mix assignment for the subsequent certification period ○ At (M0826) enter number of therapy visits indicated, or enter 000 if no therapy visits indicated, based on therapy need for the subsequent certification period beginning after the end of the current payment episode. ○ A new Plan of Care is required for the subsequent 60-day episode. </p> <p>OPTION 2: NEW PAYMENT EPISODE UPON RESUMPTION OF CARE at admission to hospital: Transfer with HHA discharge (M0100) RFA 7 at return to home care: Start of Care (M0100) RFA 1 and (M0826) enter number of therapy visits indicated for the 60 days starting with the resumption of care, or enter 000 if no therapy visits indicated. <ul style="list-style-type: none"> ○ PEP adjustment applies to original payment episode. </p> <p>Other Follow-Up Assessment: at admission to hospital: Transfer without HHA discharge (M0100) RFA 5 and (M0826) enter number of therapy visits indicated. <ul style="list-style-type: none"> ○ Although Significant Change in Condition (SCIC) adjustments are no longer available after 01/01/2008, regulatory requirements continue to mandate a comprehensive assessment update when the patient experiences a major decline or improvement in health status, as defined by the agency. </p>
6. Patient experiences a major decline or improvement (as defined by agency) without qualifying inpatient admission.	<p>12</p>

OASIS Considerations for Medicare PPS Patients (Revised October 2007)		
Type of Episode or Adjustment	OASIS Assessment: M0100 & M0826 Response Selection & Comments	
7. Subsequent 60-day episode due to the need for continuous home health care after an initial 60 day episode.	<p>Recertification (Follow-up): Conduct (M0100) RFA 4 assessment during days 56-60 of current payment episode. At (M0826) enter number of therapy visits indicated for the subsequent payment episode (60 days), or enter 000 if no therapy visits indicated.</p>	
8. Patient's inpatient stay extends beyond the end of the current certification period. (Patient returns to agency after day 60 of the certification period.) - No Recertification assessment has been completed.	<p>at admission to hospital: Transfer with/without HHA discharge (M0100) RFA 6 or 7 at return to home care:</p> <ul style="list-style-type: none"> ○ HHA will need to complete agency discharge paperwork (not OASIS) before doing a new SOC. ○ When patient returns home, new orders and plan of care are necessary. ○ HHA starts new episode and completes a new start of care assessment (M0100) RFA 1. ○ At (M0826) enter number of therapy visits indicated for the next 60 days, or enter 000 if no therapy visits indicated. 	
9. Patient receives a Recertification assessment during days 56-60, then is hospitalized before the end of the certification period. Returns home from inpatient stay on days 60 or 61.	<p>at recentification: Recertification (M0100) RFA 4 and (M0826) enter number of therapy visits indicated for the subsequent 60-day payment episode, or enter 000 if no therapy visits indicated.</p> <p>at admission to hospital: Transfer with/without HHA discharge (M0100) RFA 6 or 7 at return to home care: Start of Care/Resumption of Care:</p> <p>(M0100) RFA 1/RFA 3 and (M0826) enter number of therapy visits indicated, or enter 000 if no therapy visits indicated.</p> <ul style="list-style-type: none"> ○ If RFA 7 was completed, a new Start of Care (M0100) RFA 1 is completed upon patient's return home. ○ If RFA 6 was completed, a SOC/ROC comprehensive assessment is completed. (The HHA will not know if it is a SOC or ROC until the HHRG is calculated). ○ If the new HHRG is exactly the same as the recertification HHRG, the care is considered continuous. M0100 should be reported as RFA 3 and the assessment is a Resumption of Care. ○ If the new HHRG is <u>not</u> exactly the same as the recertification HHRG, the care is not considered continuous and the agency must complete an internal agency discharge (no D/C OASIS required). M0100 should be reported as RFA 1 and the assessment is a Start of Care, starting a new episode/certification period. New admission paperwork is not necessary, except as required by the payer or agency policy. ○ See Medicare Claims Processing manual, Chapter 10, Section 80, available at http://www.cms.hhs.gov/manuals/downloads/cic104c10.pdf 	

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
Type of Episode or Adjustment	OASIS Assessment: M0100 & M0826 Response Selection & Comments
10. Patient receives a recertification assessment during days 56-60, then experiences a qualifying inpatient admission before the end of the certification period. Returns home from inpatient stay after day 61 (or after the 1 st day of the next certification period)	<p>at recertification : (M0100) RFA 4. At (M0826), enter number of therapy visits indicated for subsequent 60-day payment episode, or enter 000 if no therapy visits indicated.</p> <p>at admission to hospital: Transfer with/without HHA discharge (M0100) RFA 6 or 7</p> <p>at return to home care: Start of Care (M0100) RFA 1 and (M0826) enter number of therapy visits indicated for the new payment episode, or enter 000 if no therapy visits indicated.</p> <ul style="list-style-type: none"> ○ The episodes are not considered continuous for billing purposes and the agency must complete an internal agency discharge (no D/C OASIS required). A new episode and certification are established, requiring completion of all required admission paperwork. ○ The RFA 6 or 7 remains as the last OASIS submission under the previous episode.
11. Patient receives a recertification assessment during days 56-60, and then experiences a qualifying inpatient admission in the new episode.	<p>at recertification: (M0100) RFA 4. At (M0826) enter number of therapy visits indicated for the subsequent 60-day episode, or enter 000 if no therapy visits indicated.</p> <p>at admission to hospital: Transfer with/without HHA discharge (M0100) RFA 6 or 7</p> <p>If RFA 7 was completed, a new Start of Care (M0100) RFA 1 is completed upon patient's return home.</p> <ul style="list-style-type: none"> ○ If RFA 6 was completed, a SOC/ROC comprehensive assessment is completed. (The HHA will not know if it is a SOC or ROC until the HHRG is calculated). ○ If the new HHRG is exactly the same as the recertification HHRG, the care is considered continuous. M0100 should be reported as RFA 3 and the assessment is a Resumption of Care. <p>(This is an example of when the first visit in the new certification period is a ROC visit.)</p> <ul style="list-style-type: none"> ○ If the new HHRG is <u>not</u> exactly the same as the recertification HHRG, the care is not considered continuous and the agency must complete an internal agency discharge (no D/C OASIS required). M0100 should be reported as RFA 1 and the assessment is a Start of Care, starting a new episode/certification period. New admission paperwork is not necessary, except as required by the payer or agency policy.
12. Pay source changes from any payer to Medicare FFS/PPS	<p>at discontinuation of previous pay source: (M0100) RFA 9 for episode under old pay source (Optional)</p> <ul style="list-style-type: none"> ○ Discharge from old pay source is not required but is recommended. <p>at initiation of Medicare FFS payment: Start of Care: (M0100) RFA 1 for new episode under PPS.</p> <ul style="list-style-type: none"> ○ A new SOC date is required for Medicare FFS/PPS, as well as a new Plan of Treatment. ○ The first covered visit <u>after</u> the Medicare FFS is effective establishes the new start of care, and a new SOC assessment should be performed on or within 5 days after this date. ○ When the old pay source required OASIS data collection, optional completion of the Discharge assessment allows outcomes from eligible episodes to be captured, and for Medicare/Medicaid patients, to contribute to outcome calculations for OBQI and OBQM reports. ○ It is highly recommended that payer source status be regularly monitored by clinicians to avoid compliance and billing challenges that will result from lacking assessments and missing HHRGs.

OASIS Considerations for Medicare PPS Patients (Revised October 2007)		
SPECIAL ISSUES RELATED TO THE TRANSITION TO PPS 2008 – December 27-31, 2007		
Type of Episode or Adjustment	OASIS Assessment:	M0100, M0090 & M0825/6 Response Selection & Comments
13. SOC IN 2007 FOR A 2007 EPISODE Patient admitted to home care during the period December 27, 2007 – December 31, 2007 for an initial 60-day episode that begins prior to January 1, 2008.	Start of Care: (M0100) RFA 1 <ul style="list-style-type: none"> ○ This assessment must be conducted with OASIS-B1 12/2002. ○ Note that the HHA has 5 days to complete the SOC assessment. <p>If the assessment is completed on 12/27/2007-12/31/2007, at (M0090) enter the actual date the assessment is completed.</p> <p>If the assessment is completed in 2008, at (M0090) enter the artificial date "12/31/2007". At (M0825) enter "0-No" or "1-Yes" to indicate if the need for therapy for the upcoming 60-day episode meets the 10-visit therapy threshold.</p>	CRITERIA FOR TEMPORARY WAIVER ALLOWING USE OF ARTIFICIAL DATE "12/31/2007" FOR M0090: <ul style="list-style-type: none"> ○ <u>RFA 1;</u> ○ <u>WHERE THE REQUIRED ASSESSMENT TIME FRAME BEGINS IN 2007 AND ENDS IN 2008; AND</u> ○ <u>THE ACTUAL ASSESSMENT COMPLETION DATE IS IN 2008; AND</u> ○ <u>THE RELATED PAYMENT EPISODE BEGINS IN 2007.</u>
14. RECERT In 2007 for a 2008 EPISODE Patient to be recertified during the period of December 27, 2007 – December 31, 2007 for an subsequent 60-day episode beginning on or after January 1, 2008, due to the need for continuous home health care after an initial 60-day episode.	Recertification (Follow-up): (M0100) RFA 4 <ul style="list-style-type: none"> ○ This assessment must be conducted with OASIS-B1 1/2008. <p>At (M0090) enter the actual date (12/27/2007 – 12/31/2007) the Recertification assessment was completed. At (M0826) enter the number of therapy visits indicated for the next 60-day episode, or enter 000 if no therapy visits indicated</p>	Recertification (Follow-up) or Other Follow-up: (M0100) RFA 4 or RFA 5 <ul style="list-style-type: none"> ○ This assessment must be conducted with OASIS-B1 12/2002. <p>If the actual assessment completion date is 12/27/2007-12/31/2007, at (M0090) enter artificial date "12/26/2007." At (M0825) enter "0-No" or "1-Yes" to indicate if the need for therapy for the 60-day episode meets the 10-visit therapy threshold.</p> <ul style="list-style-type: none"> ○ This guidance may generate a warning error message indicating the assessment date is not in compliance with the 5-day window, even though the actual data collection may have occurred in a timely and compliant manner. The HHA need not address this warning message in this special case. ○ The clinical record should include notation of application of this special scoring guidance in reporting the assessment date, which is required to facilitate appropriate payment during the transition to PPS 2008.
15. RECERT (or OTHER FOLLOW-UP) In 2007 for a 2007 EPISODE Patient to be recertified during the period of December 27, 2007 – December 31, 2007 for a subsequent 60-day episode beginning prior to January 1, 2008, due to the need for continuous home health care after an initial 60-day episode; OR Patient experienced a major decline or improvement/significant change in condition requiring a Follow-up condition during the period of assessment during the period of December 27, 2007 – December 31, 2007.		CRITERIA FOR TEMPORARY WAIVER ALLOWING USE OF ARTIFICIAL DATE "12/26/2007" FOR M0090: <ul style="list-style-type: none"> ○ <u>ONLY ON RFA 4 OR RFA 5;</u> ○ <u>WHERE THE ACTUAL ASSESSMENT COMPLETION DATE IS 12/27/2007-12/31/2007; AND</u> ○ <u>THE RELATED PAYMENT EPISODE BEGINS IN 2007.</u>

OASIS Considerations for Medicare PPS Patients (Revised October 2007)

SPECIAL ISSUES RELATED TO THE TRANSITION TO PPS 2008 – December 27-31, 2007

- 16. ROC In 2007 for a 2008 EPISODE**
- Qualifying Inpatient Stay with return to agency during the last 5 days of an episode (days 56-60), when
- o the 5 day recertification window includes at least one day within the December 27-31, 2007 period;
 - AND
 - o the patient needs continuous home health care into a subsequent episode;
 - AND
 - o the 1st day of the new cert period will be on or after January 1, 2008.
- OPTION 1: (RECOMMENDED) at hospital admission: Transfer without HHA discharge (M0100) RFA 6 at return to home care: Resumption of Care assessment (M0100) RFA 3.**
- For (M0090): If the date the assessment is completed is December 27-31, 2007, enter artificial date "1/1/2008." If the date the assessment is completed is January 1, 2008 or later, enter the actual date the ROC assessment was completed.
- o When the requirement to complete a Resumption of Care assessment overlaps with the time period requiring completion of a Recertification assessment, only the Resumption of Care assessment is necessary. (Effective October 1, 2004)
 - o For payment purposes, this assessment serves to determine the case mix assignment for the subsequent 60-day period.
 - o Patient was transferred to an inpatient facility and returns home during the last 5 days of the current episode (days 56-60). The HHA will continue to be required to conduct the Resumption of Care assessment (RFA 3) within 48 hours of the patient's return.
 - o Following this temporary guidance to enter an artificial date may generate a warning error message indicating the assessment date is not compliant with the 2 calendar day time frame for completion of a ROC assessment. The HHA need not address this warning message in this special case.
 - o The reporting of the assessment date will need to follow the above guidance in order to facilitate appropriate payment during the transition to PPS 2008.
 - o The clinical record should include notation of application of this special scoring guidance in reporting the assessment date, which is required to facilitate appropriate payment during the transition to PPS 2008.
- At (M0826) enter the number of therapy visits indicated for the upcoming 60-day episode, or enter 000 if no therapy visits indicated.

CRITERIA FOR TEMPORARY WAIVER ALLOWING USE OF ARTIFICIAL DATE "1/1/2008" FOR M0090:

- o ONLY ON RFA 3;
- o WHERE THE 48 HOUR ROC ASSESSMENT TIMEFRAME BEGINS ON OR AFTER 12/27/2007 AND ENDS PRIOR TO 1/1/2008; AND
- o THE RELATED PAYMENT EPISODE BEGINS IN 2008.

NOTE: Some data systems may not allow entry of a M0090 date later than the current date; in this situation, entry would need to be deferred until 1/1/2008 or later.

OPTION 2:
at hospital admission: Transfer with HHA discharge (M0100) RFA 7

at return to home care during days 56-60 of payment episode: new Start of Care assessment: (M0100) RFA 1.

For episodes starting on/after 1/1/2008, at (M0090) enter the actual date the assessment is completed.

For episodes starting on/before 12/31/2007, follow the guidance in Scenario #13 above.

PEP adjustment applies to previous episode.

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
SPECIAL ISSUES RELATED TO THE TRANSITION TO PPS 2008 – December 27-31, 2007	
<p>17. ROC In 2007 for a 2007 EPISODE</p> <p>Qualifying Inpatient Stay with return to agency during the last 5 days of an episode (days 56-60), when</p> <ul style="list-style-type: none"> o the 5 day recertification window includes at least one day within the December 27-31st period; <p>AND</p> <ul style="list-style-type: none"> o the patient needs continuous home health care into a subsequent episode; <p>AND</p> <ul style="list-style-type: none"> o the 1st day of the new cert period will be on or before December 31, 2007. 	<p>OPTION 1: (RECOMMENDED) at hospital admission: Transfer without HHA discharge (M0100) RFA 6 at return to home care: Resumption of Care assessment (M0100) RFA 3.</p> <ul style="list-style-type: none"> o This assessment must be conducted with OASIS-B1 12/2002. o Note that the HHA has 48 hours to complete the ROC assessment For (M0090); if the date the assessment is completed is on or before 12/31/2007, enter the actual date the assessment is completed. o If the date the assessment is completed is 1/1/2008 or later, enter artificial date "12/31/2007." o When the requirement to complete a Resumption of Care assessment overlaps with the time period requiring completion of a Recertification assessment, only the Resumption of Care assessment is necessary. (Effective October 1, 2004) o For payment purposes, this assessment serves to determine the case mix assignment for the subsequent 60-day period. o Patient was transferred to an inpatient facility and returns home during the last 5 days of the current episode (days 56-60). The HHA will continue to be required to conduct the Resumption of Care assessment (RFA 3) within 48 hours of the patient's return. o The reporting of the assessment date will need to follow the above guidance in order to facilitate appropriate payment during the transition to PPS 2008. o The clinical record should include notation of application of this special scoring guidance in reporting the assessment date, which is required to facilitate appropriate payment during the transition to PPS 2008. <p>At (M0825) enter "0-No" or "1-Yes" to indicate if the need for therapy for the upcoming 60-day episode meets the 10-visit therapy threshold.</p> <p>CRITERIA FOR TEMPORARY WAIVER ALLOWING USE OF ARTIFICIAL DATE 12/31/2007 FOR M0090:</p> <ul style="list-style-type: none"> o RFA 3; o WHERE THE REQUIRED ASSESSMENT TIME FRAME BEGINS IN 2007 AND ENDS IN 2008; AND o THE ACTUAL ASSESSMENT COMPLETION DATE IS IN 2008; AND o THE RELATED PAYMENT EPISODE BEGINS IN 2007. <p>OPTION 2: at hospital admission: Transfer with HHA discharge (M0100) RFA 7 at return to home care: new Start of Care assessment: (M0100) RFA 1.</p> <ul style="list-style-type: none"> o PEP adjustment applies to previous episode. o Follow guidance in Scenario #13 above.

For additional guidance describing steps required to create the proper payment group code for claims related to the transition to the refined HH PPS January 1, 2008 please reference: "Questions and Answers Regarding Home Health Episodes and the Transition into HH PPS Refinement" accessible at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

	Comprehensive Assessment Required?	OASIS Required?	Discharge OASIS Required?	Agency Discharge (Documented Explanation) Required?
SOC Only one visit planned & provided	Yes	<ul style="list-style-type: none"> - Not required by <u>regulation</u> - Payer may require OASIS (HHRG items) - If OASIS collected for payment, and M0150 = 1,2,3, or 4, may be submitted to State system 	No	Yes
SOC More visits planned but none provided after SOC	Yes (may not have been completed, or even started on the first and only visit)	<ul style="list-style-type: none"> - Not required by <u>regulation</u> - Payer may require OASIS (HHRG items) - If OASIS collected, and M0150 = 1,2,3, or 4, OASIS data may be submitted to State system 	No	Yes
SOC One visit made, then patient admitted for qualifying Inpatient facility stay before 2 nd visit	Yes (may not have been completed or even started on the first and only visit)	<ul style="list-style-type: none"> - Not required by <u>regulation</u> - Payer may require OASIS (HHRG items) - If OASIS collected, and M0150 = 1,2,3 or 4, OASIS data may be submitted to State system - If SOC OASIS is collected and submitted, may also complete and submit Transfer (RFA 6 or 7), but not required to do so since SOC OASIS is not required 	No	Yes
SOC One visit made but patient died before 2 nd visit	Yes (may not have been completed or even started on the first and only visit)	<ul style="list-style-type: none"> - Not required by <u>regulation</u> - Payer may require OASIS (HHRG items) - If OASIS collected, and M0150 = 1,2,3 or 4, OASIS data may be submitted to State system - If SOC OASIS is collected and submitted, may also complete and submit RFA 8 Death at Home, but not required to do so since SOC OASIS is not required 	No	Yes
SOC Visit made but patient not taken under care	No	<ul style="list-style-type: none"> - Not Required by <u>regulation</u> 	No	No
SOC RN open (nonbillable) for one time billable therapy visit	Yes	<ul style="list-style-type: none"> - Required by <u>regulation</u> - More than one visit made 	Yes - More than one visit made	Yes

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

	Comprehensive Assessment Required?	OASIS Required?	Discharge OASIS Required?	Agency Discharge (Documented Explanation) Required?
ROC Only one visit planned & provided	Yes	<ul style="list-style-type: none"> - Not required by regulation - Payer may require OASIS (HHRG items) - If OASIS collected for payment, and M0150 = 1,2,3, or 4, may be submitted to State system 	No	Yes
ROC More visits planned but none provided after ROC	Yes	<ul style="list-style-type: none"> - Not required by regulation - Payer may require OASIS (HHRG items) - If OASIS collected, and M0150 = 1,2,3, or 4, may be submitted to State system 	No	Yes
ROC One visit made, then patient admitted for qualifying Inpatient facility stay before 2nd visit	Yes	<ul style="list-style-type: none"> - Not required by regulation - Payer may require OASIS (HHRG items) - If OASIS collected, and M0150 = 1,2,3, or 4, OASIS data may be submitted to State system - If ROC OASIS is collected and submitted, may also complete and submit Transfer (RFA 6 or 7), but not required to do so since ROC OASIS is not required 	No	Yes
ROC One visit made but patient died before 2nd visit	Yes	<ul style="list-style-type: none"> - Not required by regulation - Payer may require OASIS (HHRG items) - If OASIS collected, and M0150 = 1,2,3 or 4, OASIS data may be submitted to State system - If ROC OASIS is collected and submitted, may also complete and submit RFA 8 Death at Home, but not required to do so since ROC OASIS is not required 	No	Yes
ROC Visit made but patient not taken under care	No	<ul style="list-style-type: none"> - Not required by regulation 	No	No

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

REFERENCES for Guidance:

CMS Q&As Category 2

Q19. An RN visited a patient for Resumption of Care following discharge from a hospital. The nurse found the patient in respiratory distress and called 911. There was no opportunity to complete the Resumption of Care assessment in the midst of this situation. What should be done in this situation?

A19. Any partial assessment that was completed can be filed in the patient record, but HAVEN (or HAVEN-like software) will not allow a partial assessment to be exported for submission to the State agency. In situations like this, a note explaining the circumstances for not completing the assessment should be documented in the chart. If, after the 911 call, the patient is admitted to an inpatient facility and then later returns home again, a Resumption of Care assessment would be indicated at that point. When the 911 call results in the ER treating the patient and sending the patient back home, the Resumption of Care assessment would be completed at the next agency visit.

Q23. A patient recently returned home from an inpatient facility stay. The Transfer comprehensive assessment (RFA 6) was completed. The RN visited the patient to perform the ROC comprehensive assessment but found the patient critically ill. She performed CPR and transferred the patient back to the ER where, he passed away. The ROC assessment, needless to say, was not completed. What OASIS assessment is required?

A23. The Transfer assessment completed the requirements for the comprehensive assessment. The patient did not resume care with the HHA. The agency discharge summary should be completed to close out the clinical record.

Q42. What should agencies do if the patient leaves the agency after the SOC assessment (RFA 1) has been completed and further visits were expected?

A42. Completion of a SOC Comprehensive Assessment is required, even when the patient only receives a single visit in an episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a single-visit episode, some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.

If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1, 2, 3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q43. Since RFAs 2 and 10 were eliminated in December 2002, what should we do if only one visit is made at Resumption of Care? All the references I've seen address only the issue of one visit at SOC.

A43. Because the RFA 10 response originally stated, "after start/resumption of care," we advise you to follow the same instructions you would after only one visit at SOC (i.e., the ROC comprehensive assessment is required, but OASIS data collection is not required). No discharge comprehensive assessment or OASIS is required when no additional visits are made after the ROC visit. Agency clinical documentation should indicate that no additional visits occurred after the ROC assessment, and internal agency documentation of the discharge would be expected. You should be aware that the patient will continue to appear on the agency's roster report as an incomplete episode. The patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

agency would get a warning that the new assessment was out of sequence. This will not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q46. Home health patients may return to the hospital after a single visit. Some HHAs treat these as one-visit only episodes, do not collect OASIS data, and do not bill the Medicare program. Is this acceptable? In many instances, it appears that the patients were prematurely discharged from the hospital.

A46. Yes, this is acceptable. This scenario appears to fit the criteria for one-visit only episodes for Start of Care or Resumption of Care that became effective December 16, 2002. Each patient must receive a comprehensive assessment. The agency is not required to collect the OASIS items, nor encode and submit the assessment. This assessment can be placed in the clinical record for documentation and planning purposes.

[Q&A added 06/05] [Q&A EDITED 08/07]

Q58: Medicare patient goes to hospital, agency completes RFA 6, Transfer, patient not discharged. Patient returns home with orders for one PT visit to evaluate new equipment. PT does eval and determines no further visits are necessary. Should HHA complete ROC, even though no further visits are going to be provided? And if the HHA completes the ROC, would they complete a DC on the same day?

A58: In responding to the question, it will be assumed that the single PT visit conducted at the resumption of care was a skilled and covered visit, that the resumption of care visit occurred within the existing 60-day episode, and that we are discussing a Medicare PPS patient.

A comprehensive assessment must be completed when the patient returns home from an inpatient stay of 24 hours or greater for any reason other than diagnostic tests, even though there will only be the one PT visit. The Conditions of Participation 484.55 Comprehensive Assessment of Patients, Standard (d) states: The comprehensive assessment must be updated and revised within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.

However, since 2002, OASIS is not a required part of the comprehensive assessment for known one-visit patient episodes. CMS Q&A Cat 2 Q43 clarifies that a ROC comprehensive assessment is required, even if it is the only visit conducted after the inpatient discharge, but that the assessment should be treated like a one-visit only episode at the start of care (i.e., comprehensive assessment is required, but OASIS data collection is not required). While there is not a regulatory requirement to collect OASIS as part of these assessments, there may be a reimbursement requirement by the payer to do so. No discharge comprehensive assessment or OASIS is required when only one visit is made. The agency would complete their own internal discharge paperwork.

[Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #4]

CMS OASIS Q&As Category 4b

Q21. M0100. For a one-visit Medicare PPS patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it data entered? Is it transmitted? Is a discharge OASIS completed?

A21. Completion of a SOC Comprehensive Assessment is required, even when the patient is known to only need a single visit in the episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a known one-visit episode, some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.

If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

OASIS Collection Regulation – published January 1999

§484.55 Condition of participation.

Comprehensive assessment of patients.

(b) **Standard:** Completion of the comprehensive assessment.

- (1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.

(2) Except as provided in paragraph

(b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.

(3) When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy established program eligibility.

(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than—

- (1) Every second calendar month beginning with the start of care date;
(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests;
(3) At discharge.

[Excerpt from 64 FR 3784, Jan. 25, 1999]

www.access.gpo.gov/su_docs/lfedreg/a990125c.html

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OASIS-B1 (12/2002) Data Set - Approved Final Version

The Centers for Medicare & Medicaid Services (CMS) announces the approval by the Office of Management and Budget (OMB) of the proposed changes to the reduced burden OASIS in response to the Department of Health and Human Services department-wide initiative to reduce regulatory burden in healthcare.

Since the reason for assessment 2 -Start of care with no further visits planned has been eliminated, agencies should follow these recommendations if a patient needs only one visit in the episode. According to the Condition of Participation at 42 CFR 484.55, each patient must receive a comprehensive assessment. However, in this case, the agency is not required to collect the OASIS items and the agency is not required to encode or submit that assessment. This assessment can be placed in the clinical record for documentation and planning purposes. A discharge assessment is no longer required for one-visit episodes. If the home health agency has a Medicare fee-for-service patient and expects to receive payment for the single visit, agencies must follow the PPS payment rules. This means, that for payment for Medicare fee-for-service patients, you must encode and submit reason for assessment 1 for patients with one-time only no further visits planned episodes.

Since we have eliminated reason for assessment 10 - Discharge - no further visits after start of care, there is now no discharge indicator for the patient who had only one visit, is no longer with from the agency, and there is no possibility of completing a discharge assessment. If there is only one visit made and the patient is no longer available, no discharge assessments are required.

[Excerpt from "OASIS-B1 (12/2002) Data Set – Approved Final Version]
http://www.cms.hhs.gov/HomeHealthQualityInitis/12_HHQIOASISDataSet.asp

**COMPREHENSIVE ASSESSMENT REQUIREMENTS
FOR MEDICARE-APPROVED HHAS**

PATIENT CLASSIFICATION/PAYOR	Does OASIS Apply?	Comprehensive Assessments Only Excluding OASIS	Timing of Follow-up Comprehensive Assessment
SKILLED Medicare (traditional fee-for-service) Medicare (HMO/Managed Care) Medicaid (traditional fee-for-service) Medicaid (HMO/Managed Care)	Yes	NA	Day 56-60 ²
SKILLED Non-Medicare/Non-Medicaid: Workers' Compensation Title Programs Other Government Private Insurance Private HMO/Managed Care Self-pay; other; unknown	No ³	Yes	Anytime after SOC assessment up to day 60; subsequent Followup assessment must be within 60 days ⁴
PERSONAL CARE ONLY Medicaid (traditional fee-for-service) Medicaid (HMO/Managed Care) Waiver service or HH aide services Without skilled services Non-Medicaid: Workers' Compensation Title Programs Other Government Private Insurance Private HMO/Managed Care Self-pay; other; unknown	No	Yes	Anytime after SOC assessment up to day 60; subsequent Followup assessment must be within 60 days
OASIS EXCLUDED Patients under age 18; regardless of payor source Patients receiving pre & postpartum maternity services; regardless of payor source	No - 5	Yes	Anytime after SOC assessment up to day 60; subsequent Followup assessment must be within 60 days
OASIS EXCLUDED Patients receiving only chore and housekeeping services - 6	No	No	NA

1 – HHAs may develop own comprehensive assessment for each time point, excluding OASIS.

2 – 42 CFR 484.55(d)

3 – HHAs may collect OASIS information for their own use.

4 – S&C Memo 04-45, published 9/9/04

5 – HHAs expecting payment for a pediatric or maternity Medicare patient must collect payment items to provide a HIPPS code.

6 – S&C Memo 05-06, published 11/12/04

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

OVERVIEW AND BACKGROUND

As mandated by the Balanced Budget Act of 1997, Home Health Reimbursement shifted to a prospective payment system effective October 2000. Under this system, payment is based on the patient's clinical severity, functional status, and therapy requirements. The system for wound classification uses terms such as "nonhealing", "partially granulating", and "fully granulating"; these terms lack universal definition and clinicians have verbalized concerns that they may be interpreting these terms incorrectly. The WOCN Society has therefore developed the following guidelines for classification of wounds. These items were developed by consensus among the WOCN's panel of content experts.

M0445:	Does the patient have a Pressure Ulcer?	
M0450:	Current number of Pressure Ulcers at Each Stage	
M0460:	Stage of Most Problematic (Observable) Pressure Ulcer	
1	Stage I	
2	Stage II	
3	Stage III	
4	Stage IV	
NA	No observable pressure ulcer	

Definitions:

Pressure Ulcer: Any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Shear and friction may be contributing factors. Pressure ulcers are usually located over bony prominences and are staged to classify the degree of tissue damage observed.

- **Stage I:** Non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.
- **Stage II:** Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents as an abrasion, blister, or shallow crater.
- **Stage III:** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
- **Stage IV:** Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts (tunnels) may also be associated with Stage IV pressure ulcers.
- **Non-observable:** Wound is unable to be visualized due to an orthopedic device, dressing, etc. A pressure ulcer cannot be accurately staged until the deepest viable tissue layer is visible; this means that wounds covered with eschar and/or slough cannot be staged, and should be documented as non-observable.

**WOUND OSTOMY AND CONTINENCE NURSES SOCIETY
GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS**

M0464: Status of Most Problematic (Observable) Pressure Ulcer

- | | |
|----|------------------------------|
| 1 | Fully granulating |
| 2 | Early/partial granulation |
| 3 | Not healing |
| NA | No observable pressure ulcer |

Definitions:

- **Fully granulating:**
 - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
 - no dead space
 - no avascular tissue (eschar and/or slough)
 - no signs or symptoms of infection
 - wound edges are open
- **Early/partial granulation:**
 - $\geq 25\%$ of the wound bed is covered with granulation tissue
 - there is minimal avascular tissue (eschar and/or slough) (i.e., $< 25\%$ of the wound bed is covered with avascular tissue)
 - may have dead space
 - no signs or symptoms of infection
 - wound edges open
- **Not healing:**
 - wound with $\geq 25\%$ avascular tissue (eschar and/or slough) OR
 - signs/symptoms of infection OR
 - clean but non-granulating wound bed OR
 - closed/hyperkeratotic wound edges OR
 - persistent failure to improve despite appropriate comprehensive wound management

Note: A new Stage 1 pressure ulcer is reported on OASIS as Not healing.

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

M0468:	Does the patient have a stasis ulcer?
M0470:	Current number of Observable Stasis (Ulcer(s)
M0474:	Does this patient have at least one Stasis Ulcer that cannot be observed?
M0476:	Status of the Most Problematic (Observable) Stasis Ulcer

- 1 Fully granulating
- 2 Early/partial granulation
- 3 Not healing
- NA No observable stasis ulcer

Definitions:

- Fully granulating:
 - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
 - no dead space
 - no avascular tissue (eschar and/or slough)
 - no signs or symptoms of infection
 - wound edges are open.
- Early/partial granulation:
 - $\geq 25\%$ of the wound bed is covered with granulation tissue
 - there is minimal avascular tissue (eschar and/or slough) (i.e. $< 25\%$ of the wound bed is covered with avascular tissue)
 - may have dead space
 - no signs or symptoms of infection
 - wound edges open.
- Not healing:
 - wound with $\geq 25\%$ avascular tissue (eschar and/or slough) OR
 - signs/symptoms of infection OR
 - clean but non-granulating wound bed OR
 - closed/hyperkeratotic wound edges OR
 - persistent failure to improve despite appropriate comprehensive wound management

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

M0482:	Does the patient have a Surgical Wound?
M0484:	Current number of (Observable) Surgical Wounds
M0486:	Does the patient have at least one Surgical Wound that cannot be observed due to the presence of a non-removable dressing?
M0488:	Status of the most problematic (Observable) Surgical Wound
	1 Fully granulating
	2 Early/partial granulation
	3 Not healing
	NA No observable surgical wound

Definitions:

- Description/classification of wounds healing by primary intention (i.e. approximated incisions)
 - Fully granulating/healing:
 - incision well-approximated with complete epithelialization of incision
 - no signs or symptoms of infection
 - Early/partial granulation:
 - incision well-approximated but not completely epithelialized
 - no signs or symptoms of infection
 - Not healing:
 - incisional separation OR
 - incisional necrosis OR
 - signs or symptoms of infection
- Description/classification of wounds healing by secondary intention (i.e., healing of dehisced wound by granulation, contraction and epithelialization)
 - Fully granulating:
 - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
 - no dead space
 - no avascular tissue (eschar and/or slough)
 - no signs or symptoms of infection
 - wound edges are open.
 - Early/partial granulation:
 - ≥ 25% of the wound bed is covered with granulation tissue
 - there is minimal avascular tissue (eschar and/or slough) (i.e., <25% of the wound bed is covered with avascular tissue)
 - may have dead space
 - no signs or symptoms of infection
 - wound edges are open
 - Not healing:
 - wound with ≥ 25% avascular tissue (eschar and/or slough) OR
 - signs/symptoms of infection OR
 - clean but non-granulating wound bed OR
 - closed/hyperkeratotic wound edges OR
 - persistent failure to improve despite comprehensive appropriate wound management

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

GLOSSARY

Avascular:	Lacking in blood supply; synonyms are dead, devitalized, necrotic, and nonviable. Specific types include slough and eschar.
Clean Wound:	Wound free of devitalized tissue, purulent drainage, foreign material or debris
Closed Wound Edges:	Edges of top layers of epidermis have rolled down to cover lower edge of epidermis, including basement membrane, so that epithelial cells cannot migrate from wound edges; also described as epibole. Presents clinically as sealed edge of mature epithelium; may be hard/thickened; may be discolored (e.g., yellowish, gray, or white).
Dead Space:	A defect or cavity
Dehisced/Dehiscence:	Separation of surgical incision; loss of approximation of wound edges
Epidermis:	Outermost layer of skin
Epithelialization:	Regeneration of epidermis across a wound surface
Eschar:	Black or brown necrotic, devitalized tissue; tissue can be loose or firmly adherent, hard, soft or soggy.
Full Thickness:	Tissue damage involving total loss of epidermis and dermis and extending into the subcutaneous tissue and possibly into the muscle or bone.
Granulation Tissue:	The pink/red, moist tissue comprised of new blood vessels, connective tissue, fibroblasts, and inflammatory cells, which fills an open wound when it starts to heal; typically appears deep pink or red with an irregular, "berry-like" surface
Healing:	A dynamic process involving synthesis of new tissue for repair of skin and soft tissue defects.
Hyperkeratosis:	Hard, white/gray tissue surrounding the wound
Infection:	The presence of bacteria or other microorganisms in sufficient quantity to damage tissue or impair healing. Wounds can be classified as infected when the wound tissue contains 10^5 (100,000) or greater microorganisms per gram of tissue. Typical signs and symptoms of infection include purulent exudate, odor, erythema, warmth, tenderness, edema, pain, fever, and elevated white cell count. However, clinical signs of infection may not be present, especially in the immunocompromised patient or the patient with poor perfusion.

**WOUND OSTOMY AND CONTINENCE NURSES SOCIETY
GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS**

Necrotic Tissue:	See avascular.
Non-granulating:	Absence of granulation tissue; wound surface appears smooth as opposed to granular. For example, in a wound that is clean but non-granulating, the wound surface appears smooth and red as opposed to berry-like.
Partial Thickness:	Confined to the skin layers; damage does not penetrate below the dermis and may be limited to the epidermal layers only
Sinus Tract:	Course or path of tissue destruction occurring in any direction from the surface or edge of the wound; results in dead space with potential for abscess formation. Also sometimes called "tunneling". (Can be distinguished from undermining by fact that sinus tract involves a small portion of the wound edge whereas undermining involves a significant portion of the wound edge.)
Slough:	Soft moist avascular (devitalized) tissue; may be white, yellow, tan, or green; may be loose or firmly adherent
Tunneling:	See sinus tract
Undermining:	Area of tissue destruction extending under intact skin along the periphery of a wound; commonly seen in shear injuries. Can be distinguished from sinus tract by fact that undermining involves a significant portion of the wound edge, whereas sinus tract involves only a small portion of the wound edge.

Press Release
Pressure Ulcer Stages Revised by NPUAP
National Pressure Ulcer Advisory Panel
Washington, DC
February 2007



Further description:

Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

*Bruising indicates suspected deep tissue injury

Stage III:

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Further description:

The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Stage IV:

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Further description:

The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable:

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further description:

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

The staging system was defined by Shea in 1975 and provides a name to the amount of anatomical tissue loss. The original definitions were confusing to many clinicians and lead to inaccurate staging of ulcers associated or due to perineal dermatitis and those due to deep tissue injury.

The proposed definitions were refined by the NPUAP with input from an on-line evaluation of their face validity, accuracy clarity, succinctness, utility, and discrimination. This process was completed online and provided input to the Panel for continued work. The proposed final definitions were reviewed by a consensus conference and their comments were used to create the final definitions. "NPUAP is pleased to have completed this important task and look forward to the inclusion of these definitions into practice, education and research", said Joyce Black, NPUAP President and Chairperson of the Staging Task Force.

For more information, contact npuap@npuap.org or 202-521-6789

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SKIN LESION/OPEN WOUND

LESION/WOUND (MO440)

PICC line (lesion only)

Pin sites

Central line

Implanted infusion devices

Venous access devices

Wounds with staples or sutures

“OLD” surgical wound with scar or keloid formation (lesion only)

SURGICAL WOUND (MO482)

Medi-port site (even if well healed and not being used)

“Other” *implanted* infusion devices

Venous access devices (implanted devices)

Orthopedic pin sites

Central lines

Stapled or sutured incisions

Debrided graft sites

Wounds with drains

Muscle flap to a pressure ulcer

(A muscle flap performed to *surgically replace* a pressure ulcer becomes a surgical wound and no longer a pressure ulcer)

NOT CONSIDERED LESIONS/WOUNDS (MO440)

“Ostomies” (Gastrostomy, Urostomy, Cystostomy Tracheostomy

Peripheral IV sites

NOT CONSIDERED SURGICAL WOUNDS (MO482)

PICC line (because it is peripherally inserted)

Pressure Ulcer that has been surgically debrided ONLY remains a pressure ulcer
NOT a surgical wound.

"OLD" surgical wounds with scar or keloid formation (classify as a lesion at
MO440).

IN SUMMARY:

A peripheral IV is NOT a lesion or a wound.

A PICC line is a lesion but NOT a wound.

Ostomies are NOT lesions or wounds.

Implanted infusion devices, central lines and vascular access devices ARE
considered lesions and surgical wounds.

OASIS and HAVEN Help Resources

A variety of resources have been developed to assist you as you implement OASIS in your agency. Please notice that you will contact a different resource for OASIS data collection, HAVEN software issues and transmission of data.

Questions regarding OASIS patient assessment and data collection regulations should be directed to:

Joyce Rackers, RN, OASIS Education Coordinator for Missouri, Joyce.Rackers@dhss.mo.gov

Website: <http://www.dhss.mo.gov/HomeCare>

Phone number: 573/751-6336 Fax number: 573/751-6315

Questions regarding HAVEN software (but not related to transmission of data) should be directed to:

IFMC National HAVEN Help Line

available 7:00 a.m. to 7:00 p.m.

Toll free phone number: 877/201-4721 Toll free fax number: 888/477-7871

HAVEN email address: haven_help@ifmc.org

Questions regarding the AT&T Dialer should be directed to:

MDCN Helpline

Toll free phone number: 800/905-2069 or email mdcn.mco@palmettoga.com.

Questions regarding data submission to the State of Missouri should be directed to:

Debi Siebert, OASIS Technical Coordinator for Missouri, Debi.Siebert@dhss.mo.gov

OASIS data submission Help Line: 573/751-6336 OASIS data submission Fax Line: 573/751-6315

Summary of OASIS Web Pages and Corresponding Addresses

CMS OASIS Home Page

<http://www.cms.hhs.gov/>

Overview

http://www.cms.hhs.gov/OASIS/01_Overview.asp#TopOfPage

Regulations

http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage

OASIS Data Sets

http://www.cms.hhs.gov/OASIS/046_DataSet.asp#TopOfPage

HAVEN Data Entry Software

http://www.cms.hhs.gov/OASIS/045_HAVEN.asp#TopOfPage

OASIS Data Submission Specifications

http://www.cms.hhs.gov/OASIS/04_DataSpecifications.asp#TopOfPage

OASIS User's Manual

http://www.cms.hhs.gov/OASIS/05_UserManual.asp#TopOfPage

Outcome-based Quality Monitoring Reports (OBQM)

http://www.cms.hhs.gov/HomeHealthQualityInits/18_HHQIOASISOBQM.asp#TopOfPage

Outcome-based Quality Improvement Reports (OBQI)

http://www.cms.hhs.gov/HomeHealthQualityInits/16_HHQIOASISOBQI.asp#TopOfPage

State OASIS Education Coordinators

<http://www.cms.hhs.gov/OASIS/Downloads/OASISeducationalcoordinators.pdf>

State OASIS Automation Coordinators

<http://www.cms.hhs.gov/OASIS/Downloads/OASISautomationcoordinators.pdf>

More helpful web pages:

Outcome Based Quality Improvement

<http://www.obqi.org/>

QIES Technical Support Office

<https://www.qtso.com/>

Home Health Quality Initiative

<http://www.cms.hhs.gov/HomeHealthQualityInits/>

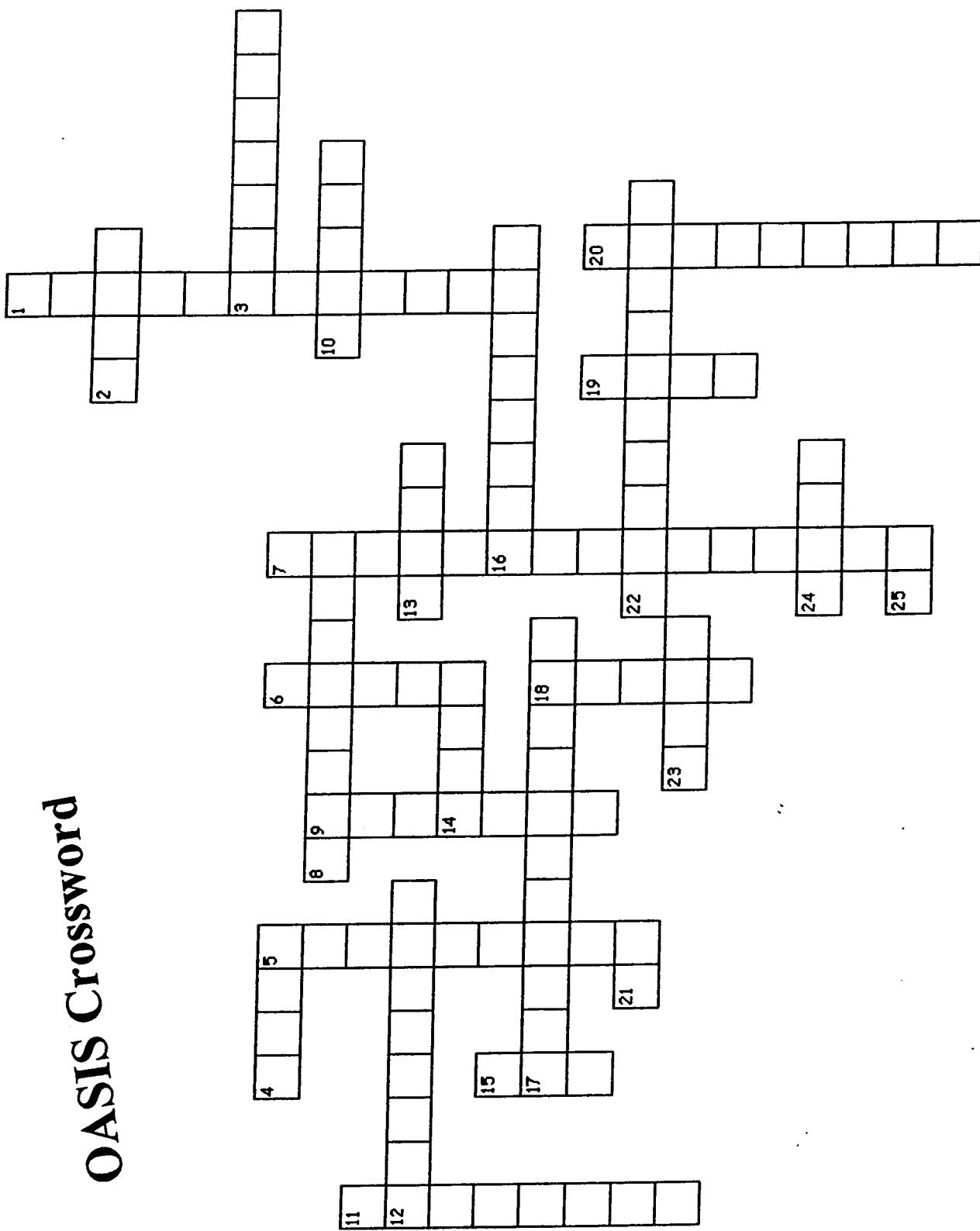
Home Health Information Resource

<http://www.cms.hhs.gov/center/hha.asp>

Home Care Website

<http://www.dhss.mo.gov/HomeCare>

OASIS Crossword



OASIS Crossword Clues

Across

2. These "patterns" allow the care provider to move quickly through the sections of the OASIS.
3. Clinicians should minimize the use of "not applicable" and _____ answer options.
4. Outcome Based Quality Improvement Reports (abbreviation).
8. SOC= first _____ visit.
10. OASIS responses should be selected that describe the patient's _____ status most of the time during the specific day under consideration.
12. Federal regulation requires the initial assessment visit be conducted within 48 hours of a _____.
13. When calculating the days you have to complete the start of care (SOC) comprehensive assessment the SOC is day _____.
14. When a patient is discharged from an inpatient stay in the last 5 days of the 60-day episode, the OASIS assessment that needs to be completed is a ROC. (True or False?)
16. If a patient died before being formally admitted to an inpatient facility, do you collect OASIS for death or do a transfer OASIS?
17. The clinician should use both interview and _____ to collect the OASIS data.
21. Who can perform the comprehensive assessment when PT is ordered along with an aide?
22. The OASIS definition for inpatient status requires the patient to be admitted for greater than 24 hours and not for _____ testing.
23. Although there will no longer be reimbursement for a significant change in the patient's condition in the middle of an episode, the following comprehensive assessment is still a federal requirement (abbreviation).
24. How many calendar days are allowed to complete the start of care comprehensive assessment?
25. Who must perform the initial as well as the comprehensive assessment when RN and PT are both ordered at start of care?

Down

1. Start of Care date is when the first _____ service is delivered.
5. Does 'transfer' mean transfer to another setting or transfer to an inpatient facility?
6. If your agency misses the 5-day recent window, your agency is required to discharge the patient. (True or False?)
7. The OASIS follow-up comprehensive assessment required to be completed during the last 5 days of each 60 - day episode is called _____.
9. This assessment determines patient's immediate needs and homebound status.
11. Missouri Quality Improvement Organization (QIO).
15. For patients already on service with a home health agency, regulations require this assessment to be done within 48 hours of a hospital discharge (abbreviation).
18. Data set used in home health.
19. What date do you list on the OASIS for M090 when information is gathered on day one, two, three and four?
20. The time points when an OASIS comprehensive assessment is required to be completed are: SOC, ROC, Transfer, Recertification, SCIC and _____.